

MEDICAL WORKFORCE IN OBSTETRICS AND GYNAECOLOGY

'Changing Times'

Chairman's Review

Introduction

The Medical Workforce Advisory Committee has spent the last year looking at the impact that the loss of so many doctors in training is having on the delivery of the present service. The inevitable reduction in the seniority of the training workforce will soon lead to a shortfall in the numbers completing training. This at a time when there are so many proposals for change within the delivery of training and service.

While the aim of these changes is to improve training across the grades, to improve care for women and to improve working lives they come at a time when the Specialty is facing a crisis.

The Medical Workforce Advisory Committee's role is to incorporate these changes as they impact on the numbers of doctors required to deliver the service and to ensure that the numbers of trainees achieve a balance with career opportunities that will become available anytime from 5-8 years after the doctor enters the training grade.

Planning the requirements of the workforce of the future has never been so difficult and success is crucial to ensure the provision of a safe service and a credible training system.

Why then are we in a position so very different from only 3 years ago?

The introduction of structured training in 1996 should have made workforce planning easier, instead we have moved from a crisis of "over producing" to a crisis of deficit and hence a shortage of consultants in less than 4 years.

Calman training coincided with a dramatic reduction in consultant expansion. In 1996 consultant expansion was running at 5%, by 1999 consultant expansion was <1%. Why there was such a profound and sustained reduction in consultant opportunities remains unclear. The problem was, however, that the number of NTN's created at the transition to structured training assumed a continued consultant expansion. When this did not occur it was postulated that there would be an excess of CCST holders over predicted consultant opportunities. The specialty was seen to be "overproducing" rather than failing to expand and reductions in training numbers were enforced.

The numbers of NTN's appointed were restricted and there was an overall reduction in the number of trainees in the system. In 1997 there were 1,037 SpRs, 700 career and 337 overseas. In 2002 the number has fallen to a total of 788 SpRs, 447 career and 341 overseas. A 36% reduction in the number of UK trainees in less than 5 years.

In 1999, in response to Clinical Governance issues raised by the publication of the fourth and fifth CESDI report, the Confidential Enquiry into Maternal Deaths and in recognition of the "Changing Expectations" as highlighted by the District Audit report, the College published the report of a Joint Working party "Towards Safer Childbirth". This report identified on the grounds of patient safety the need to increase the consultant presence on the labour ward and the realisation that more senior input is required in all areas as the specialty moves towards a consultant based service.

In response to this College initiative consultant expansion improved and has been sustained at levels greater than 5% since 2000. As a result of this very welcome initiative the excess of CCST holders has failed to materialise and the deficit predicted by this College and highlighted to the Medical Workforce Review Team up to two years ago is now looming.

Other factors have contributed to the impending deficit. An assumption that Type 1 training would be complete in five years has proved false. The average length of training is closer to seven years. The increase in the number of trainees training flexibly has continued at a rate of 15-20%. The majority of these trainees

entered the training programme as full time. Predictions in terms of length of training for this group were therefore inaccurate further contributing to the workforce deficit.

Ironically, Government calls for consultants to deliver increasing amounts of service and the need to address the European Working Time Directive will now increase the need for additional consultants.

Changes are required in service delivery which need to be embraced by the profession as we work towards implementing a service in line with the 21st century.

The RCOG Annual Census

This is the 14th Annual Workforce Report and is based on the 14 May 2002 census of England and Wales.

The task of completing the forms, collating the data and producing the report is enormous and is understood and appreciated. Grateful thanks go to all those involved in this arduous process.

The information contained within this report is obtained from the data collected on the census form. It is understood that while this information is not always completely accurate it is certainly the most reliable and robust data available.

Comparisons made between the census data and the Deans' database has identified discrepancies. Subsequent clarification has been important when discussing workforce planning with the Medical Workforce Review Team.

Particular thanks must go to Caro Allen, the Secretary to the Medical Workforce Advisory Committee. Mrs Allen has the task of obtaining the completed returns and then validating and processing the data. It is through Mrs Allen's close attention to detail that the report achieves such a high standard.

The RCOG Submission on Specialist Registrar Numbers.

Every year the College is invited to meet with the Medical Workforce Review team to discuss the current state of the workforce. A working model is produced and agreed. The accuracy of this model is very important as it is from this that calculations are made for the coming year.

The Medical Workforce Review Team makes recommendations to Ministers as to the advisable number of SpRs that should be recruited to ensure sufficient trained consultants for the future.

The aim of the meeting in 2002 was to ensure that the MWRT understood that continued restriction of training numbers was not sustainable. Close examination of the Lead Dean's database of trainees and comparison with the data collected by the College census in May 2002 revealed that the numbers of trainees in the system, as a result of the continued savage cuts in training numbers imposed on Obstetrics and Gynaecology by Ministers, was so low that a deficit was predicted.

The following points were made;

- Continued consultant expansion has ensured that the predicted excess of CCST holders has not materialised
- Continued restriction of workforce numbers would ensure an even bigger deficit in consultant numbers than was currently anticipated

A robust case was made for an increase in training numbers in addition to replacement posts.

The MWRT reported the results of this discussion to the Workforce Numbers Advisory Board (WNAB) and Ministers agreed the following:

An additional 63 NTN's to be made available, in addition to replacement numbers, for recruitment to obstetrics and gynaecology. No additional funding is available for these posts. The training opportunities will come about as a result of conversion of LAT and Type 2 training posts and should therefore be cost-neutral.

The quick appointment of these training numbers is essential, and being cost-neutral will enable this process. However, a true expansion of the Specialty will not occur without additional funding.

In addition 4 fully funded NTN's are now available for recruitment to Reproductive and Sexual Health posts.

Implementation will be by the Workforce Development Confederations and the Lead Dean. Allocation of the numbers will be spread across Deaneries and will reflect the reduction of numbers that individual deaneries have sustained.

Future Medical Workforce Planning

Workforce planning is difficult with so many variables which need to be taken into account. However, never again should the College allow the attempted resolution of an impending crisis by introducing measures that will have profound effects on the future workforce. That lesson has been learnt.

The College reports "A Blueprint for the Future" and "Towards Safer Childbirth" have committed the Specialty to increasing consultant involvement in patient care, to ensure better care for women and their babies. Many more consultants will be needed. The College will continue to argue the case for increasing training numbers as a way of ensuring that care for women will continue to improve.

We can only hope that our arguments will be heard.

European Working Time Directive (EWTD)

There are several parts to the European Working Time Directive

Maximum 48 hours of work per week and a minimum of;

- 4 weeks paid annual leave per year;
- 11 hours continuous rest in any 24 hour period;
- 24 hours continuous rest in any 7 day period;
- 20 minutes rest in any shift longer than 6 hours;
- Maximum 8 hour shift for designated night workers.

Derogations can be sought for any of these limits except the 48-hour working week.

Individuals can opt out of the Directive but their hours must be monitored.

The European Working Time Directive is Health and Safety legislation, adopted by the European Commission in May 2000. Implementation of the European Working Time Directive is a legal requirement for the NHS.

The legislation previously excluded junior doctors but applies to all career grade doctors and should have been adopted by all Trusts.

Application of the Directive to trainees

- August 2004 58hours
- August 2007 56hours
- August 2009 48hours

Optional extensions

- August 2009 52hours
- August 2011 52hours
- August 2012 48hours

In August 2004 the European Working Time Directive requires that doctors in training require a reduction in their working hours to 58 hours per week. The new junior doctors contract pre-empted the European Working Time Directive, from August 2003 the average working week for doctors in training has been 56. Significantly, the 11 hours' rest requirement in every 24 hours will apply to junior doctors by August 2004 as will the SiMAP ruling.

SiMAP ruling

As a result of a recent European Court ruling doctors who are required to be resident on-call in a hospital will be deemed to be working for the whole of the resident on-call period (whether or not they actually get called). This will accelerate the move from on-call rotas. This means that rotas that currently have 5 or 6 doctors will need to have 8-10 doctors on them.

The European Working Time Directive already applies to career grade doctors. The BMA believes that at least 15% of consultants work in excess of 48 hours a week on average. Given the onerous nature of on-call commitments, particularly in obstetrics, it is likely that a large number of consultants in obstetrics and gynaecology are currently in breach of the European Working Time Directive.

Compliance with the Directive demands a reduction in workloads and massive consultant expansion now.

NHS Professionals

Medicine has traditionally been seen as a full-time continuous commitment. However, many doctors choose not to work full-time and many stop working completely as the conflicting demands of family and professional life become too great.

There has also been a recent trend towards early retirement, the average age of retirement in 2001 was 57. The most recent census has shown this to have risen to 61, but still a large portion of the most experienced part of the workforce is retiring early. We are losing a wealth of experience at a time when a shortened length of training and reductions in hours inevitably means that the consultants of the future, as a body, are less experienced.

NHS Professionals driven by the NHS Plan and Improving Working Lives has been set up to maximise the utilisation of available doctors. The service has 5 initial services that are developing over time.

- Flexible careers scheme;
- Support for new international doctors;
- A not for profit high quality locum service;
- A national register of locum activity;
- Support for appraisal and revalidation.

NHS Professionals could have a significant impact on the workforce in obstetrics and gynaecology. The Flexible Careers Scheme(FCS) is open to the following doctors:

- Those wishing to work less than 50% of full time;
- Those wishing to have a career break while keeping in touch with the profession;
- Those wishing to take time out from training;
- Those currently not working who wish to return to practice;
- Those nearing retirement who wish to continue working but at a different pace;
- Those who have fully retired and want to return perhaps working at a different pace.

This scheme could be a way of retaining senior consultants continuing to work within the NHS but at a more acceptable pace. In all cases pension rights are protected.

Within the trainees there are now more female UK trainees than male, at any one time approximately 15% of female trainees are working flexibly. To qualify for entering the flexible training grade the trainee must work at least 60% of the equivalent whole time trainee. This scheme now offers the possibility of maintaining clinical skills and a training number while taking a break from training. It will be important to monitor carefully the uptake of this scheme so that large numbers of training numbers are not removed from circulation making workforce planning even more difficult.

The SHO grade

There are major proposals for change to the SHO grade. The Department of Health recently published a report proposing changes to the role of SHO training and the way basic specialist training is structured. The proposals are for a two-year foundation programme to incorporate the current pre-registration and first SHO year, affording young doctors the opportunity to obtain a structured grounding in basic medical skills. As part of these two years they will have exposure to a variety of different Specialties, including obstetrics and gynaecology,

After completing the foundation programme the trainee will then go on to complete specialist training. The trainee will enter their chosen specialty and, assuming adequate assessments, will move “seamlessly” through to CCST.

The College has commented on these proposals. In general there is agreement that there is a need to reform the SHO grade. However, it is felt that the precise skill targets that the trainee is expected to obtain during the foundation year need to be better defined.

While welcoming the principle of a single training grade, a major concern expressed frequently is the perceived inability of the current RITA process to prevent the progress of trainees who are not achieving appropriate targets during training. A more robust system of assessment would need to be introduced to support progress through the training programme.

The earlier award of a CCST is not clearly linked with reforms to the SHO grade and must be considered separately.

Recruitment to Obstetrics and Gynaecology

There is a BMA cohort study of 1995 medical graduates, the study is longitudinal and follows the career paths of 545 doctors. In June 2002 the seventh report was published. In 1995 5% of the cohort stated an intention to train in obstetrics and gynaecology, by 2000 that figure had dropped to 1%. In 1995, 3% of males and 7% of females were wishing to pursue a career in our specialty, by 2000 this had dropped to 0.8% and 2% respectively.

The main reason for changing career direction was “hours of work and working conditions” other reasons included:

- Domestic circumstances
- Career and promotion prospects
- Competition for SpR posts

A recently published paper (BMJ 2003;326:194-195) reported on a survey of career choices of UK graduates in 1999 and 2000 revealed that concerns over career prospects in obstetrics and gynaecology have reduced the numbers choosing this specialty to the lowest ever recorded level.

Obstetrics and gynaecology has a major recruitment problem. Lack of training opportunities and concerns about the future job description of the new style consultant obstetrician and gynaecologist is dissuading young doctors.

The current cohort of trainees recognise the inevitability of residency but expect to be adequately remunerated both in time and money. Urgent discussions with the BMA are required to ensure that any future negotiations about Consultant Terms and Conditions adequately address this issue.

Sub- Specialty Training (SST)

As a result of specialty negotiations in early 2002 it was agreed that two additional fully funded NTN's should be made available for training in gynaecological oncology. This was in recognition of the increasing difficulty in filling Consultant posts in this sub-specialty. In addition there were 10 unfunded NTN's made available to train in gynaecology oncology and bids for these numbers were invited. Only three bids were received highlighting the main issue in sub-specialty training is the lack of funding. Recruitment to this area of training will also prove increasingly difficult as the seniority of the training workforce diminishes.

In recognition of these difficulties, at the most recent round of specialty negotiations the College made a case for "ringfencing" NTN's for subspecialty training with funding attached. The particular difficulties experienced by the Faculty of Family Planning and Reproductive health were highlighted.

Four additional fully-funded NTN's were awarded for training in Sexual and Reproductive Health (Community Gynaecology).

Workforce planning must consider the specialisation that is occurring in obstetrics and gynaecology. The exercise to try to ensure that the number of trainees entering the subspecialties will meet the requirements of the workforce is now underway.

Conclusions

In the coming year there are going to be many challenges for the Medical Workforce Advisory Committee to consider. Encouraging recruitment is essential. Implementation of the European Working Time Directive will be very challenging to a specialty with an extremely depleted workforce and no possibility of cross-specialty cover.

The Workforce Advisory Committee will continue to push for increasing training numbers to ensure adequate specialty expansion. Recognising that workforce planning is difficult and accurate prediction as to the number of training slots required is almost impossible. Consultant expansion is required but funding issues and the autonomy of Trusts and now the PCTs make the accurate assessment of future requirements and hence the number of trainees required to achieve a steady state very difficult.

There is a growing acceptance that senior cover is required in larger units 24 hours a day. To achieve this will require significant consultant expansion and therefore expansion of training numbers. Uniformity of opinion in the specialty is required, however, to add weight to the argument.

Rather than being distracted by arguments that individuals are not prepared to be resident and residency is not achievable we should be discussing whether on grounds of patient safety we as a specialty think it is necessary. Negotiations should then start from that point.

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